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Beyond Consent—The Ethics of Decision-Making in Emergency Medicine

EDITOR'S NOTE: Karen Tait is a third-year medical student at the University of California, San Francisco. Gerald Winslow is Assistant Professor of Religion at Walla Walla College, Walla Walla, Washington and a PhD candidate in Religion and Society at the Graduate Theological Union, Berkeley. These students participated in a summer fellowship program supervised by the Health Policy Program at the University of California, San Francisco. They had an eight-week rotation on the Trauma Service at San Francisco General Hospital with Dr. George F. Sheldon as their preceptor. Their impressions and analysis of the ethical and informed consent considerations of the emergency situation were felt applicable for Trauma Rounds. The authors wish to thank Michael Garland, PhD, and Albert Jonsen, PhD, for invaluable guidance and comments.

INCREASING ATTENTION is being given to the problems of informed consent in the practice of medicine.[1-3] Although obtaining informed consent for medical interventions is generally considered imperative, emergency medical care is a widely recognized exception. The ethicist Ramsey[4] defends the right of patients to consent to treatment but acknowledges that in medical emergencies assumed or implied consent is sufficient. Shartel and Plant[5] suggest that it is more appropriate to recognize that the law grants authority to act without reference to an injured person's consent, and that consideration of a "fictitious" consent adds unnecessary confusion. Recently, Johnson and Trimble[6] have discussed the problems encountered in treating a verbally abusive and unwilling patient in an emergency and concluded that physical restraint should be used when necessary and that thorough evaluation and treatment should be carried out regardless of the patient's consent. Only a few discussions[7,8] have attempted to resolve the many ambiguities of informed consent in an emergency, and these are largely from a legal point of view.

The purpose of the present study is to analyze the *ethical* issues related to the problems of consent and decision-making in emergency medicine. The authors observed emergency room practices on the trauma service of the San Francisco General Hospital for two months. Each of the authors was assigned to one of the two trauma teams at the hospital. Observations were made during numerous shifts, interviews conducted with staff members and rounds attended. Special attention was given to the decision-making process of the hospital's emergency room staff and the trauma service. Logs were kept and later analyzed in detail. The primary concern was for critical emergencies, such as trauma, myocardial infarction and drug overdose. Some of these patients were unconscious; others were conscious with varying levels of awareness. For simplicity, the word "emergency" is restricted to critical cases in which lives depended on immediate supportive treatment.

Emergency medicine is characterized by the need for rapid intervention, sometimes calling for aggressive measures at a time when pertinent in-

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formation is inaccessible and medical histories are sketchy. Moreover, if a patient is unconscious or irrational, or an inpenetrable language barrier exists, explaining the necessary medical procedures becomes impossible. Other patients at various levels of consciousness or apparent rationality, express the desire *not* to be treated in spite of manifestly serious conditions. This predicament is sometimes managed by having a close family member give "proxy" consent in order to satisfy legal requirements. But when the patient is unaccompanied by a family member, even proxy consent is impossible.

If a physician determines that a patient is incapable of making a rational decision, the medicolegal principle of "reasonable therapeutic restraint" may be appropriate. The courts have generally protected physicians who take whatever measures are deemed necessary in a medical emergency.[9] However, whether or not a physician acts, he *may* be legally liable. If he treats the patient without the patient's consent, the physician may be sued on the grounds of assault and battery. If, on the other hand, the physician does not restrain and treat the patient, he may be sued for negligence.[6]

Measures taken contrary to the patient's will require an accurate evaluation of the patient's mental status which, under emergency circumstances, is subject to a wide array of influences. Rational judgment may be affected by such conditions as cerebral hypoperfusion, central nervous system injury and drug intoxication. Psychological defense mechanisms such as denial and regression[10] may be used by injured patients and result in a failure to recognize the need for treatment or a childlike dependency on others.

Medical advances in resuscitation techniques, especially for trauma victims, have given impetus to aggressive treatment of most patients. For example, a 19-year-old-man was brought to the emergency room with a stab wound to the chest which penetrated the right ventricle of the heart. Upon arrival he was in severe shock and hypothermic (92°F). In earlier years it probably would have been considered impossible to save such a patient. However, aggressive resuscitative measures were initiated. In the trauma room, blood loss from the wound was reduced by thoracotomy before the patient was taken for emergency surgical operation. During several weeks in the intensive care unit, the man failed to respond to verbal stimuli, although his overall condition gradually improved. Eventually, he regained mental alertness and subsequently recovered to the extent that he was able to return to work.

In another case, extensive resources, including the services of a large proportion of the available personnel, were utilized in the treatment of a 34-year-old woman suffering from a severe upper gastrointestinal hemorrhage. In spite of all efforts at resuscitation, neurological evidence of brain death became apparent within 24 hours. Consent was obtained from the family to remove her kidneys for transplantation. Three days following admission the woman died. From the perspective of the medical staff this case did not represent an unmitigated failure. The family was reassured that the obligation to use all available means to save the patient's life was fulfilled and, moreover, the donation of the patient's two kidneys benefited two repicients.

The ethical approaches utilized by the medical personnel when making decisions in emergency situations seemed consistent with a predetermined decision to maintain life in virtually all emergency cases. Summarized as an operating principle, the prevalent attitude appeared to be: Always respond with whatever measures seem necessary in order to maintain (or resuscitate) vital functions whether with, without or against the patient's expressed will whenever urgent circumstances make attempts to obtain the patient's informed consent impractical.

In neither of the two cases just cited did the patients have the opportunity to consent to treatment. Presumably they would both have wanted all measures taken that might have been essential in attempting to preserve their lives. In recent years, however, this principle of preserving life whenever possible, sometimes called "vitalism," has come under attack. Fletcher argues that the "vitalistic ideas that life as such is sacrosanct, the highest good and somehow both sacred and untouchable, is obviously not tenable in actual practice."[11,12] McCormick[13] claims that quality-of-life decisions must be made; the vitalism which has characterized much of medical practice is a kind of "idolatry."

Along with criticism of the vitalistic approach, recent years have witnessed an expanding discussion of the patient's right to terminate or forego certain types of treatment—even essential life-saving treatment.[14] Commentaries on the well-known case of Karen Quinlan have indicated a similar concern.[15] Some patients have written

"living wills" which set the conditions and limits for life-saving intervention,[16] but a physician is more likely to encounter the desire to stop treatment as a verbal expression by the patient.

In commenting on a case in which a burned patient wished to terminate treatment, Engelhardt argues that the patient's decision must be honored, yet he also allows for the notion that *emergency* treatment might legitimately be forced on a patient in order to guarantee a later exercise of rational choice. ". . . One can justify treating a burned patient when first admitted even if that person protested: One might argue that the individual was not able to choose freely because of the pain and serious impact of the circumstances, and that by treating initially one gave the individual a reasonable chance to choose freely in the future."[17]

The making of decisions for another without regard for the involved person's will is often discussed under the heading of "paternalism."[18] Such a practice seems to run counter to the generally held principle of respecting the autonomy of individual persons. Paternalistic decisions are, however, frequently made. Many philosophers have recognized the limited but unmistakable legitimacy of this category of actions in certain situations. Children and even mentally competent adults are guarded against experiences and practices considered detrimental to their well-being, such as the use of street drugs.

It should also be recognized that even when a physician relinquishes the decision-making power, a kind of paternalistic judgment has been made. After initially assessing the patient's competence, the responsible physician provides or withholds the approval necessary to implement a patient's decision. For example, in the hospital studied, two patients under the same doctor's care wished to leave the hospital against medical advice on the same evening. Both patients were in need of observation, one for symptoms of suspected acute appendicitis and the other for complications of a drug overdose. The first man appeared to be rational and cooperative but preferred to watch for developing symptoms at home. The second patient showed his ineptitude during an attempt to get out of bed by upsetting his IV stand and breaking the bottle. The physician in charge released the first man with instructions to call at the first sign of problems but retained the second man against his wishes. Of course, in either case the patient could presumably undertake legal action to challenge the physician's judgment, but the potential for such action in the emergency setting is virtually nil. Furthermore, securing a court's judgment simply moves the power of paternalistic ratification from the physician to the court.

What is needed is a principle for action which respects the patient's autonomy and takes into account the need to make some paternalistic decisions for the patient. Philosopher John Rawls approaches the problem by asking his readers to imagine a scene in which a group of people have been gathered for the purpose of establishing rules of justice which are as fair as possible. The participants must be rational and self-interested. They must be able to calculate the consequences of their decisions, but they must not know how any of the proposed alternatives will affect their own particular interests. In this so-called "original position" no one is able to act on personal biases. For example, in making rules for just behavior in a medical emergency the rule makers would not know whether in fact they might be patients or physicians. With this perspective in mind Rawls offers the following principle:

> Paternalistic decisions are to be guided by the individual's own settled preferences and interests insofar as they are not irrational. . . . As we know less and less about a person, we act for him as we would act for ourselves from the standpoint of the original position. We try to get for him the things he presumably wants whatever else he wants. We must be able to argue that with the development or the recovery of his rational powers the individual in question will accept our decision on his behalf and agree that we did the best thing for him.[19]

In acting for someone as "we would act for ourselves from the standpoint of the original position," an attempt would be made to make choices with which a rational and prudent person would likely agree. The central concern is *not* the probability that the *actual* person in question will retrospectively agree with the decisions. The crucial point is that the decisions must be justifiable to a theoretical third party—a *reasonable person* in the patient's position.

This ethical principle provides no specific content for decisions, but it does give a basis on which emergency medical decisions can be made. It protects physicians from a patient who, on the basis of idiosyncratic preferences, disagrees with the decisions which have been made. It also pro-

tects a patient from a physician who adheres to norms differing from those expected of a representative reasonable person.

Is the established emergency procedure of preserving life whenever possible in harmony with the above principle? In order to assert that it is, we must assume that most reasonable people wish to go on living. Whatever values are maintained, the one "good" which is essential to the realization of nearly all others is life itself. This does not mean that life is the highest good or an absolute good in the "vitalistic" sense. Rather, life is seen as a relative good which is, nevertheless, basic and precious—a value that ought to be preserved as requisite for other values.

Even if the decision to commit suicide might be deemed rational in some situations, it seems virtually impossible in emergency medicine to take such a consideration into account. One might imagine a case in which a person who had apparently attempted suicide would be accompanied by a family member to the emergency room. The family member might produce a suicide note and show evidence of an overdose of a particular drug. Even if the legal restrictions prohibiting a physician's involvement as an accomplice in a suicide could be set aside, the physician would still find it necessary to decide in favor of the preservation of life. There would be no time to seek answers to absolutely essential questions. The physician could not determine, for example, whether the patient might not actually be the victim of an attempted homicide. Acting on a bias in favor of life would seem to be the most reasonable course under the circumstances.

Summary

Practical obstacles to the use of informed consent in emergency medicine often necessitate the exclusion of a patient's participation in the decision-making process. A principle has been sought which will take into account both respect for the personal autonomy of a patient and the need to make paternalistic decisions. Decisions made from the standpoint of the "original position" appear to satisfy these requirements by resorting to the theoretical standards of unbiased *reasonable persons*. In practice, decisions made in favor of preserving life, irrespective of the patient's expressed consent, are justifiable on this basis. The rapid pace of emergency care cannot take into account the idiosyncratic wishes of desperately ill persons when many factors which in all likelihood have interfered with rational thinking are present. Emergency life-preserving measures taken by the physician seek ultimately to restore patients' autonomy. Under more stable circumstances a better evaluation of patients' capacity for decision-making can be achieved. No longer under the influence of immediate physical and emotional trauma, patients should then be able to make choices that better reflect their concerns and goals.

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